Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Epidemiological Abuse

To the Editor: I was disturbed to read the editorial entitled, "Epidemiological Abuse," in the October-December 1990 issue of the *Journal of the American Board of Family Practice*,[1] especially because its author, G. Gayle Stephens, M.D., is such a respected and eloquent spokesman for our field. I believe that many other family physicians will reject his arguments and his conclusions and will question whether the successes of epidemiology are indeed responsible for the adverse circumstances that he purports to describe.

Dr. Stephens asserts (without citation of specific evidence) that "family physicians take a beating from epidemiologists, many in our own ranks," [p 308] and seems to imply that, because the reasons are complex, it is acceptable not to diagnose "depression, substance abuse, and child abuse . . . in large numbers of our patients." [p 308] He then argues that, because we see patients one at a time, our agendas are not those of preventive medicine. In my estimation, it is precisely the role of epidemiology to take us out of the office and into the community, lest we smugly conclude that if we don't clearly see the importance of specific health problems (such as depression, substance abuse, and child abuse) in our daily practices, then the magnitude of the problem(s) must not be great and must fall outside our realm of responsibility.

It is demeaning to the family physician to imply that reasoned analysis of epidemiologic data is beyond the skills or interests of the practitioners and that such data become coercive because we are powerless to identify their weaknesses. Indeed, one might argue that epidemiology is the basic science of family practice in much the same way that immunology is the basic science of rheumatology. We need to know the differences between relative risk and absolute risk, so we do not feel as manipulated as Dr. Stephens does when he reads epidemiologic studies. Am I naive in believing that today's family physicians are taught to analyze epidemiologic data and to draw appropriate conclusions from them?

Dr. Stephens's paper purports to describe epidemiological abuse. With the exception of his fouth example, which is drawn from *Molecules of the Mind: The Brave New Science of Molecular Biology* (a book that is unlikely to influence the practice of very many family physicians), most of the arguments Dr. Stephens presents are straw men. It is absurd to suggest that epidemiologists, or any other medical scientists, aspire to cause physicians to be "knee-jerk compliant to every significant value of *P* or to feel guilty about it." [p 308]

Any science, including Pasteur's microbiology and Banting and Best's physiology (which are presented as the apotheosis of science by Dr. Stephens), can be abused. In fact, much of the epidemiological abuse in the editorial is perpetrated by Dr. Stephens himself. It is most disturbing that family physicians are told that "research surveys and questionnaires about our practices are often stacked against us," a comment that is followed by an implication (although not a direct statement) that we would be well advised to stop cooperating with such surveys. I hope this admonition was not Dr. Stephens's intent.

One-half of the Original Articles and the Clinical Review in the issue in which the editorial appeared were epidemiologic studies,[2-4] and others relied heavily on epidemiology or epidemiologic methods.[5,6] In an earlier editorial, Dr. Stephens observed that "the successful practice of medicine consists, in large part, in asking and answering questions." [7 p 226] This also describes the successful practice of epidemiology, and the answers to the questions asked by epidemiologists regularly inform family physicians in their daily clinical practices. While I agree with Dr. Stephens's position that not all data demand an immediate change in behavior, I do not believe that family physicians have been victimized by epidemiology. When epidemiological abuse exists, it should be clearly identified and castigated. The baby should not be thrown out with the bath water, however, and family physicians should generally embrace, rather than reject, epidemiology.

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References

1. Stephens GG. Epidemiological abuse. J Am Board Fam Pract 1990; 305-9.
2. Kvale JN, Gillanders WR, Bass TF, Hofstetter CR, Gemmel D. Health and poverty among elderly persons: a community-oriented primary care survey. J Am Board Fam Pract 1990; 3:231-9.
3. Bell MM, Joseph RN. Screening 1140 fifth graders for hypercholesterolemia: family history inadequate to predict results. J Am Board Fam Pract 1990; 3:259-63.
4. Pacala JT. The relation of serum cholesterol to risk of coronary heart disease: implications for the elderly. J Am Board Fam Pract 1990; 3:271-82.
5. Clement KD, Christenson PD. Papanicolaou smear cell recovery techniques used by primary care physicians. J Am Board Fam Pract 1990; 3:253-8.

6. Goldschmidt RH, Dong BJ, Saba GW, DeRemer PA, Legg JJ. AIDS at the crossroads: a report from the 1990 International Conference on AIDS—San Francisco. J Am Board Fam Pract 1990; 3:297-304.
7. Stephens GG. Easy questions, difficult answers. J Am Board Fam Pract 1990; 3:224-6.

The above letter was referred to the author in question, who offers the following reply:

To the Editor: Dr. Sugarman's objections to my editorial are important. While his was the only critical letter I received (so far), I'd guess that he is correct in believing that "many other family physicians will reject (my) arguments and conclusions . . . ." There is an issue here that needs to be debated; i.e., how far family practice should be transformed into community medicine.

Julian Tudor Hart, a Welsh general practitioner, has argued the affirmative case eloquently in his recent book, *A New Kind of Doctor*,[1] and John Fry describes how this is happening in Great Britain in a guest editorial in this issue of *JABFP*.[2]

The relation between public health and medical practice was a hot issue in the early decades of this century. Both Paul Starr[3] and James Burow[4] discussed it from economic and political perspectives, and Sinclair Lewis[5] included it his novel, *Arrowsmith*, with the character, Dr. Almus Pickerbaugh. Arrowsmith's vocational dilemma—general practice versus public health versus research—was not resolved in the novel any more than it is today.

What is the core work of family physicians? The work that deserves our highest priority of time, energy, and skill? During the last 20 years, we have had a number of contenders for defining our best vocational self-understanding—general practice, family medicine (narrowly defined), generic primary care, biopsychosocial medicine, and now community-oriented primary care—to name some of the most alluring. I am on the record, ad nauseum, for defending personal medicine, as defined and described by the likes of Peabody, Houston, Balint, Tumulty, and Berger, to occupy first place in my professional heart and life.

I do not assume that Dr. Sugarman objects to this priority—perhaps it is his, too. But when he writes that ". . . epidemiology is the basic science of family practice, in much the same way that immunology is the basic science of rheumatology . . . ," I have to resist such a narrow understanding of our work. It represents the sort of excess that my editorial criticized.

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P.S. Since writing this reply, a wonderfully relevant piece by Jared Goldstein has appeared in the *Hastings Center Report* (Desperately seeking science: the creation of knowledge. Hastings Cent Rep 1990; 20:26-36). I recommend it to any who are interested.

References

1. Hart J. A new kind of doctor: the general practitioner's part in the health of the community. London: Merlin Press, 1988.
2. Fry J. Traumatic evolution: recent changes in British general practice. J Am Board Fam Pract 1991; 4:125-6.
3. Starr P. The social transformation of American medicine. New York: Basic Books, 1982.
4. Burow J. American Medical Association. Voice of American medicine. Baltimore: The Johns Hopkins Press, 1963.
5. Lewis S. Arrowsmith. New York, Scarborough, Ontario: New American Library, 1924.

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